equivalent to that of a decreasing term life insurance policy needed to pay off the outstanding loan balance. In addition, the loan must be related to patient care and be considered an allowable debt as described elsewhere in this plan.

7. Non-Nursing Facility Costs. Facilities which have a portion of the facility that is not certified for Medicaid should allocate the costs associated with that portion of the facility as non-allowable costs. These costs should be allocated based on square footage for fixed costs (i.e. utilities, depreciation, interest), actual salaries and fringe benefits of employees working in the non-certified area, and based on patient days for non-direct costs (i.e. administrative costs, dietary costs), or other methods which are acceptable by Medicare per HIM-15 guidelines.

8. Nurse Aide Testing and Training. Nurse aide training and testing is a non-allowable cost. Reimbursement for nurse aide training and testing is made to the provider through direct billing.

9. Other Non-Allowable Costs. The cost of any services provided for which residents are charged a fee is a non-allowable cost. In addition, the amount paid for any item subject to direct reimbursement by the Division of Medicaid is a non-allowable cost.

10. Penalties and Sanctions. All penalties and sanctions assessed to the facility are considered non-allowable costs. These include, but are not limited to, delinquent cost report penalties, Internal Revenue Service penalties, and insufficient check charges.

11. Television. The cost of providing television service to residents is a non-allowable cost if residents are charged a fee for this service.

12. Vending Machines. The cost of providing vending machines is a non-allowable cost. If a cost finding is not submitted with the cost report, the vending machine revenues will be offset against allowable costs.

2-2 Nurse Aide Training and Competency Testing

Reasonable costs of training and competency testing of nursing assistants in order to meet the requirements necessary for the nursing assistants to be certified in accordance with the Omnibus Budget Reconciliation Act of 1987 are to be billed directly to the Division of Medicaid. The nursing facility will be directly reimbursed by the Division of Medicaid following policies stated in the Mississippi Medicaid Nursing Facility Manual. Payments made by Medicaid will be based on the facility's Medicaid utilization percentage which will be calculated for each state fiscal year. Each facility's percentage will be calculated once for each fiscal year, no more than forty-five (45) days in advance of the start of the state fiscal year and will be based upon data from the most recent cost report available. Facilities which change ownership will use the old owner's percentage for the remainder of the fiscal year. A facility's interim percentage will be eighty percent (80%) if no cost report data is available. The percentage will be adjusted to actual upon receipt of a cost report; the adjustment will be retroactive. The training costs must be incurred for an employee of a Medicaid participating nursing facility who attends a program approved by the Mississippi State Department of Health. Nursing facilities must account for and request for reimbursement for training and competency testing costs in accordance with policies and procedures adopted in the Mississippi Medicaid Nursing Facility Manual. All costs billed to the Division of Medicaid are subject to verification of the expense prior to being processed for payment. The Division of Medicaid shall claim these expenses as administrative costs on the HCFA-64 Quarterly Statement of Expenditures.

The costs of in-service training of certified nursing assistants are a nursing facility cost and are an allowable cost to be included on the nursing facility's cost report.

2-3 Related Party Transactions

A. Allowability of Costs

Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership of 5% or more equity, control, interlocking directorates, or officers are allowable at the cost to the related organization. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. These requirements apply to the sale, transfer, lease-back or rental of the property, plant or equipment or purchase of services of the related organization.

Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in the Provider's Reimbursement Manual, SSA-HIM-15, Chapter 10 and Section 2150.3.

B. Determination of Common Ownership or Control

In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other.

C. Exception

An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the fiscal agent and/or the Division of Medicaid:

1. That the supplying organization is a bona fide separate organization.

2. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization.

3. That the services, facilities, or supplies are those which are commonly obtained by nursing facilities from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by nursing facilities.

4. That the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

Where all of the conditions of this exception are met, the charges by the supplier to the provider for such services or supplies are allowable as costs.

D. Definitions

1. Reasonable - The consideration given for goods or services is the amount that would be acceptable to an independent buyer and seller in the same transaction.
2. Necessary - The purchase is required for normal, efficient, and continuing operation of the business.

3. Costs related to patient care - Include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others.

4. Costs not related to patient care - Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees, cost of drugs sold to other than patients, cost of operation of a gift shop, and similar items.

5. Related to provider - The provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. The existence of an

immediate family relationship will create an irrebuttable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests are met. The following persons are considered immediate family for these purposes: (1) husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) step-parent, step-child, step-sister, and step-brother; (5) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law; (7) grandparent and grandchild.

6. Common ownership - Common ownership exists when an individual or individuals possess ownership to the extent that significant control can be exercised.

2-4 Private Room Charge

The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room due to medical necessity prescribed and ordered by a physician. No extra charge will be made to the resident, his/her family, or the Medicaid program.

When a resident is in a private room, by resident or family choice, a resident may be charged the difference between the private room charge and the semi-private room charge if the provider informs the

resident at the time of his/her admission of the amount of the charge. Semi-private room accommodations are covered by the Medicaid reimbursement rate.

2-5 Reserved Bed Days Payments

The Division of Medicaid will reimburse a long-term care facility for bed days held for Title XIX recipients under the following conditions and limitations.

A. Hospital Leave

Facilities will be reimbursed a maximum of fifteen (15) days for each hospital stay for residents requiring acute hospital care. Residents must receive continuous acute care during acute hospital leave. Should a resident be moved from an acute care hospital bed to a bed in the hospital that is certified for a less than acute care service, the Medicaid program may not be billed for any period of time in which services other than acute care services are received by the resident. The period of leave will be determined by counting, as the first day of leave, the day the resident left the facility. A leave of absence for hospitalization is broken only if the resident returns to the facility for 24 hours or longer.

The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed may not be filled with another resident during the covered period of hospital leave. Facilities may not refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires nursing facility services.

Each facility must establish and follow a written bed-hold and resident return policy which conforms to requirements of the Medicaid State Plan and other state and federal regulations. Hospital leave days may not be billed if the facility refuses to readmit the resident under their resident return policy. Repayment will be required of a facility which bills Medicaid for fifteen (15) days of hospital leave, discharges the resident, and subsequently refuses to readmit the resident under their resident return policy when a bed is available. Leave days must be billed in accordance with the applicable Division of Medicaid provider manual.

B. Home / Therapeutic Leave

The Division of Medicaid will reimburse long-term care facilities for home/therapeutic leave days with limits per resident, per state fiscal year (July 1 - June 30), as determined by the Mississippi State Legislature. Nursing Facility are allowed fifty-two (52) days per state fiscal year in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. ICF-MR residents are allowed eighty-four (84) days per state fiscal year in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. PRTF residents are allowed eighteen (18) days per state fiscal year. Leave days must be determined, authorized and billed in accordance with the applicable Division of Medicaid provider manual.